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Title of Hearing: Chairman Herger Announces Hearing on Medicare Premium Support Proposals 5/29/12

Dear Chairman Dave Camp,

I am a Radiologist Assistant (R.R.A.) residing in New Jersey. I am writing to alert you to a serious problem facing advanced-level radiologist extenders in my profession and all Medicare patients in need of quality imaging services. I respectfully request that you enact legislation that would resolve this situation - H.R. 3032, the Medicare Access to Radiology Care Act, as it will directly help *modernize the Medicare benefit and improve Medicare's long-term fiscal solvency.*

Please read the "RA Issue Brief" below. It will further explain the radiologist assistant (R.A.) profession and what H.R. 3032 would accomplish. Currently 29 states recognize the importance of radiologist assistants in the delivery of medical imaging care, but given the lack of federal recognition, CMS is not able to give its beneficiaries access to this care.

Reps. Dave Reichert (R-WA), Jim Matheson (D-UT), Pete Olson (R-TX), Bill Pascrell (D- NJ), and other co-sponsors have introduced H.R. 3032, which would expressly recognize the R.A. as a non-physician provider under Medicare. Under the bill, state law would govern scope of practice and physician supervision levels for procedures performed by RAs. Only radiologists would bill the Medicare program for RA services, but the services performed by an RA would be reimbursed at a lower rate than that of radiologists. Medicare has already realized the cost saving benefit that mid-level physician extenders provide and passage of H.R. 3032 would enable Medicare beneficiaries' access to expertise and services that radiologist assistants provide. This proposal enjoys the full support of everyone in the medical imaging community. H.R. 3032 undoubtedly preserves patients' access to radiology care, medical education programs and jobs and will not increase the federal deficit. I hope I can count on your support as a co- sponsor.

RA Issue Brief: Current Medicare Policy Limits Options for Providing Access to Quality, Safe, and Cost-Effective Medical Imaging Services

Issue: The rising demand and clinical need for timely medical imaging services and the increased complexity of radiologic studies have placed unsustainable pressure on our health care delivery system, limiting access to quality care for Medicare beneficiaries. The solution developed by nationally-recognized organizations - the radiologist assistant (RA) --requires appropriate recognition by Medicare.

Solution: Amend the Social Security Act to (1) permit radiologists to utilize the services of radiologist assistants which the radiologist assistants are legally authorized to perform under state laws and under the conditions established by the state; and (2) reimburse for services performed by RAs at 85% of the amount otherwise applicable for services when performed by a physician. H.R. 3032, the Medicare Access to Radiology Care Act, would accomplish these objectives. Introduced by Reps. Reichert (R-WA), Matheson (D-UT), Olson (R-TX), and Pascrell (D-NJ), the legislation is bipartisan and has the full support of all stakeholders in the medical imaging community.

Background: As far back as 1996, the U.S. Department of Defense recognized the need for an advanced practice radiologic technologist to alleviate problems caused by insufficient numbers of radiologists in the armed forces. As demand increased for radiology services and the shortage of radiologists worsened, the American College of Radiology (ACR), the American Society of Radiologic Technologists (ASRT), and the American Registry of Radiologic Technologists (ARRT) collaboratively developed the concept of the RA - a radiographer with additional education, specialized clinical training, and advanced certification. The RA is an advanced-level radiographer who assists, but does not replace, the radiologist in the diagnostic imaging environment. The RA must complete a rigorous academic program encompassing a nationally-recognized curriculum and a radiologist-directed clinical preceptorship and must pass a nationally-recognized certification examination. An RA educational program must award a baccalaureate degree at a minimum and educate students to perform diagnostic imaging and interventional radiology procedures within the RA's scope of practice. Today, 13 universities offer education and supervised clinical training for the RA, and 29 states license or certify RAs. An RA can be certified by the American Registry of Radiologic Technologists as a registered radiologist assistant or by the Certification Board for Radiology Practitioner Assistants as a radiology practitioner assistant. RAs always practice under the on- site supervision of a radiologist, thus ensuring high quality care. Their advanced education and training enable them to perform assessments and procedures (excluding interpretations) that traditionally are performed by the radiologist. ACR, ASRT, and ARRT have worked together to ensure consistency in education, scope of practice, and certification standards for the RA. The Society of Radiology Physician Extenders (SRPE) joined these efforts as an organization advancing continuing education and professional development for the radiologist assistant. Unfortunately, current Medicare regulations limit the functions and duties that may be performed by RAs, largely because Medicare does not explicitly recognize RAs as a separate class of practitioners. Instead, Medicare currently views RAs as being equivalent to radiologic technologists, who do not have the education, training, or expertise that RAs have. Thus, the Centers for Medicare and Medicaid Services (CMS) applies the same supervision requirements to procedures performed by RAs that it applies to procedures performed by RTs. For example, CMS requires "personal" supervision (where the physician must be physically present in the room) for certain procedures being performed by RAs or radiologic technologists. Application of this standard to RAs ignores the fact that the majority of states (as well as ACR, ASRT, SRPE and ARRT) have determined that RAs may safely and effectively perform these same procedures under "direct" supervision, where a physician does not need to be present in the room when the procedure is performed, as long as he or she is physically present in the hospital or office suite. Thus, Medicare's restrictive supervision requirements are contrary to most states' scope of practice requirements and supervision standards for RAs and prevent the effective use of RAs in hospital and radiology practice settings. If CMS permits RAs to furnish care consistent with their state-specified scope of practice, radiologists will have more time to review and interpret medical images and will be available for more complex procedures and consultations with referring physicians. This would

significantly improve efficiency. Medicare beneficiaries would receive more timely imaging services and diagnoses and higher quality medical care. It would help resolve many challenges faced by beneficiaries in accessing care in rural and underserved areas. We believe that physician supervision requirements for imaging procedures performed by RAs within their scope of practice should reflect what the RAs are permitted to do under their respective state laws as well as the states' supervision standards where applicable. Where the state law provides that the RAs are subject to the "direct" supervision of the radiologist for certain procedures, the Medicare program should apply that supervision standard as well. Applying a reporting modifier or procedures completed with participation of an RA would distinguish them from procedures performed by radiologists and would assist with quality monitoring. In addition, applying an 85% reimbursement level for RA-performed services offers the potential for Medicare cost savings and would be consistent with how other non-physician providers have been treated under Medicare. Finally, this legislation would enable Medicare to meet an important objective of a reformed health care system - to lower costs while improving patient access through the use of qualified non-physician providers where possible.

Sincerely,

M. J. Swierczynski R.R.A.